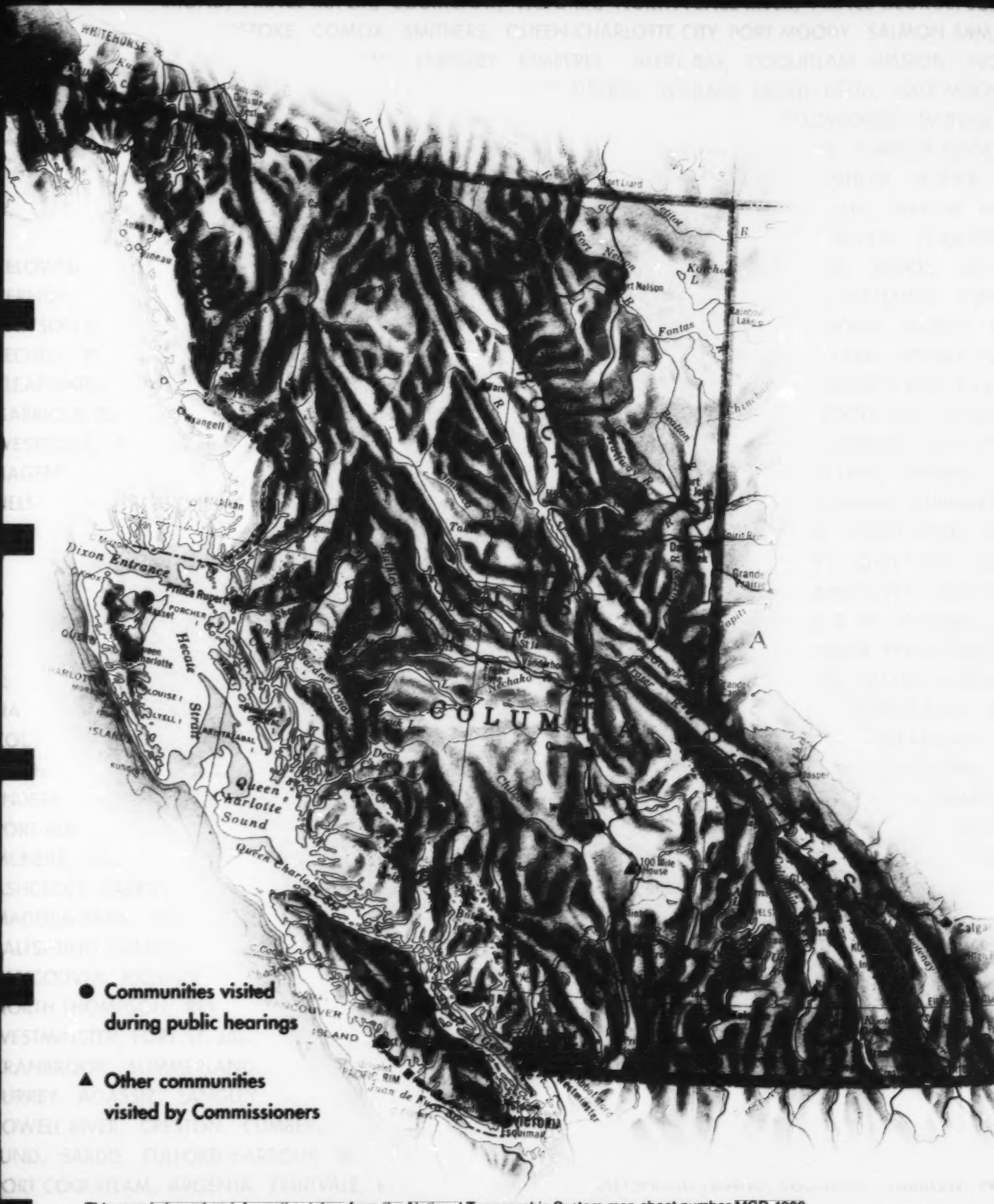
A GREAT SYSTEM, BUT...

WHAT YOU TOLD THE BRITISH COLUMBIA ROYAL COMMISSION ON HEALTH CARE AND COSTS

Province of British Columbia



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The British Columbia Royal Commission on Health Care and Costs

COMMISSIONERS

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Mrs. Marguerite Ford
Mr. David Sinclair
Dr. Robert Evans
Mr. Kenneth Fyke
Dr. William Webber

To those who have guided us:

When we began The Royal Commission on Health Care and Costs, we said that we would hear anyone who wished to speak to us and travel to any place where the number of people wanting to meet us would warrant the expense. The result is that in the last eighteen months we have travelled 16,000 kilometers, visited 51 communities and met many, many people. The process was even more valuable than we thought it would be, and the information you have given us will help shape our report.

We have chosen the title *A Great System, But...* to reflect the theme of the vast majority of briefs that this commission has received. You are proud of the health care system you have built, of the people who work in it and of the quality of care you receive. But...

The opinions given here are not the opinions of this commission. They are your opinions, sampled and sorted using the commission's terms of reference as broad guidelines. We hope that they convey a sense of the thousands of issues that have been brought to our attention and the magnitude of the task that all of us who care about the health of British Columbians have taken on.

The Commissioners and staff
of The Royal Commission

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1991

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N A M E S A N

There is no way to tell you everything we have been told. There is no way to list every name, every topic, every calling or every cause. This newsletter is a sampling of what you said, nothing more.

Your submissions describe most British Columbians as very fortunate and our health care system as one of the best in the world. Most of us are born healthy and will probably live that way well into old age. But some are not so lucky.

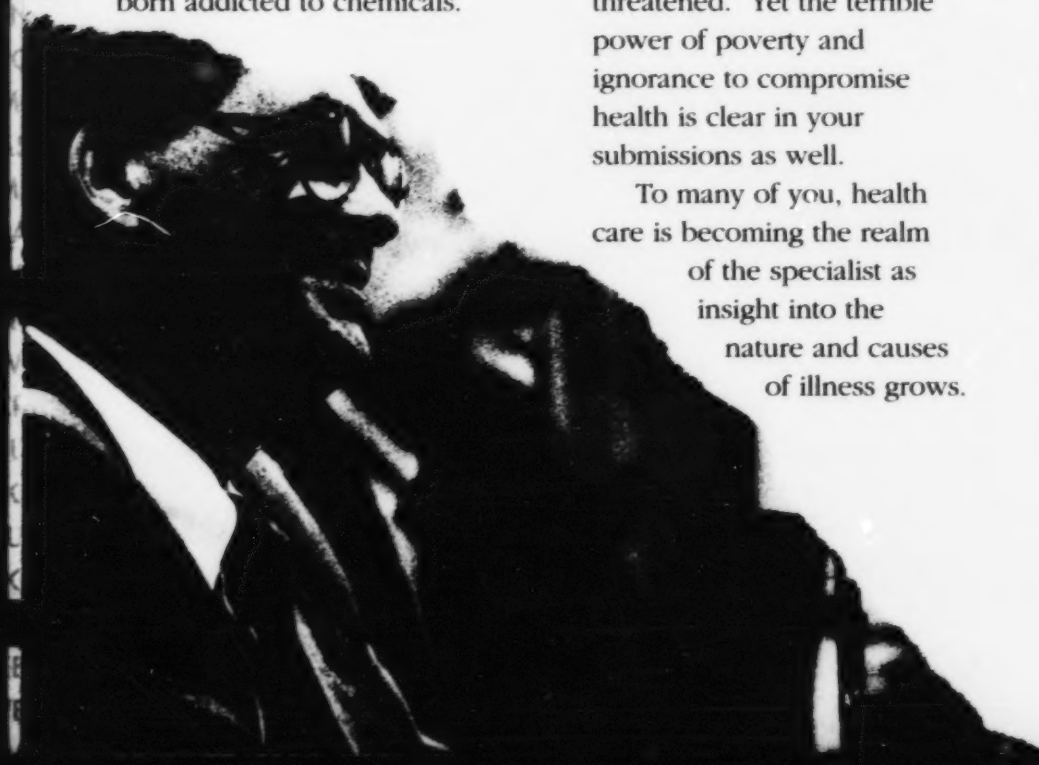
Some children are born needing care for prolonged periods of time, perhaps for life. Others are poisoned in the womb by alcohol, or are born addicted to chemicals. Still others are born healthy only to have every opportunity taken from them. These children have illness thrust upon them. They are damaged and abused, hurt for life in harsh and unforgiving home environments.

The notion of health as an empowering resource for living is often referred to in your submissions, and the commission has been privileged to hear and receive testimony to the inestimable value of health. There is abundant evidence throughout of an intense motivation to support and care for people of all ages whose health is impaired or threatened. Yet the terrible power of poverty and ignorance to compromise health is clear in your submissions as well.

To many of you, health care is becoming the realm of the specialist as insight into the nature and causes of illness grows. You raise ethical dilemmas and legal questions. You worry about the environment and the future of our health. There is a sense of unease that our capabilities have outstripped our willingness to choose if, when and how we should intervene. There are warnings of the risk of becoming overly dependent on complex and expensive technologies at the expense of community care, primary care, alternative therapies or a simpler approach. Only one of you thinks we should scrap the whole of our present system and adopt the American model of health care. All of you show a sense of caring and community that speaks well for the future.

This commission has heard over 900 groups and individuals speak on the health and health care of British Columbians. We have received in total over 1450 briefs. Thousands of pages, millions of words. There are over 23,000 references to *health*, 12,000 to *people* and 1,600 to the word *help*.

But the numbers are easy to list. It is what they represent that counts.



North Shore News / Terry Peters photo

D N U M B E R S

On behalf of all of us

This commission has heard eloquent, moving and selfless advocacy.

We have heard it:

On behalf of all British Columbians.

On behalf of children, the unborn, babies, women, the elderly, the poor, native peoples, new immigrants.

On behalf of the sick, the suffering, the injured, the abused, the impaired, the handicapped, the dying. On behalf of their families and their loved ones.

If you had to pay for the total service you wouldn't be able to maintain that level of quality. There's no way on earth you could do it without volunteers...

On behalf of those with Alzheimer's disease, multiple sclerosis, cardiovascular disease, mental illness, addictions, schizophrenia, paraplegia, Parkinson's disease, cancer, diabetes, cerebral palsy, pelvic inflammatory disease, osteoporosis, arthritis, Huntington's disease, learning disabilities, Lyme disease, muscular dystrophy, AIDS, sensory impairments, cystic fibrosis, epilepsy, amyotrophic lateral sclerosis, hepatitis, myalgic encephalomyelitis, eating disorders, vaccine damage, chronic pain, head injuries, spina bifida, hydrocephalus, renal failure, cerebrovascular disease, pulmonary disease, neurological damage, dementias...

We need answers to such questions as: What are the characteristics of good care?, How do we measure effectiveness?, How do we measure success? These are difficult questions, yet important topics for us to address.

Sometimes it's difficult to tell where the dividing line is between Social Services and Health and sometimes, when nobody is sure where they belong, they don't belong anywhere

There is a strong need for a vision for our health care system to give it purpose and direction. Inclusive in this would be a long range plan which seems to be currently lacking in favour of partisan politics.

Overall, according to the submissions, it's a good health care system. But it is not working as well as it could, or should. In places it is unfair, inefficient and inadequate, and fundamental changes must be made in the way it operates.

In general, you feel that there is a lack of local control of the decision-making process and in the delivery of health care services. The organization of the system should promote continuity of care and enable people to move smoothly from one service to another, preferably in their home community. Better yet, in their homes.

Direction:

- The long term goals of planning and management need to be clearly stated.
- Health promotion and the prevention of avoidable injuries and illness should be given a higher priority in policy making and in action.

Structure:

- The health care system is shaky in some places and too rigid in others. The division of responsibilities and the lack of communication among government ministries and within the Ministry of Health causes the duplication of work and gaps in health care services.
- Communicating with centralized agencies is often unproductive. Many times information on the rationale for agency decisions just can't be found.
- Agencies need to be better coordinated and their roles better defined. Policies should be explicit.

Management:

- There needs to be stronger incentives and more practical support for the effective and efficient management of the health care system's resources.
- Managing the cost of health care services is impossible if the costs of the services are unknown. Access to accurate information is an absolute prerequisite to good management.
- Education in management, and management skills are needed.

Accessibility:

- The majority of British Columbians have reasonable access to high quality health

care, but a number do not. There is a perception that because of an inability to recruit and retain health care professionals, inadequate funding, or the shortcomings of management and the infrastructure, equal access to health care is compromised in BC.

• Many of you feel that the door to the health care system may be open but it is difficult to reach. Poverty, language difficulties, mental illness and remoteness from highly centralized services are all seen as reducing the ability of people to find appropriate care. Who you are and where you live are critical in determining how accessible care will be. If you are sick and poor, there is a lack of mental health services, home care, health care for women, health care for children, for natives, for the poor and for the elderly. If you are sick, poor and living in a remote area of the province, there is difficulty in receiving care that would be considered basic in a big city.

• Many of you told us that the accessibility of health care decreases the further you are from a major city. In the north and in remote communities this is partly due to the chronic inability to recruit or retain doctors, nurses, therapists and support personnel.

• The concentration of specialists and high tech equipment in urban and metropolitan centres creates access problems for people from rural BC. Although the media concentrate on reporting delays in providing procedures such as open heart surgery, waiting lists exist for a wide range of services.

• Long periods may elapse between the time certain procedures or therapies are determined to be necessary and when they can be provided.

Paying for it all.

• The vast majority of your submissions call for more resources to address the health care needs of British Columbians. There are also a number of calls for a more rational and equitable method of funding the health care system. More programs, more people, more training, more institutions and better management. Relatively few of you, though, suggest how these additional services and resources are to be paid for.

• According to some submitters, abolishing BC's present system of health care insurance premiums and increasing income taxes is a fairer method of raising revenues for health care. The use of provincial lotteries is also recommended, as well as raising the taxes currently applied to alcohol and tobacco to help defray the health and health care costs of these products.

• Running counter to the general view were several suggestions that user fees be used to augment the health care budget.

Our basic health care dilemma is that we have invented more health care than we can afford to deliver.

We shall remain a forward-looking place, and a people who wish to lead rather than follow through this time of change in our way of doing things... They say Rome wasn't built in a day, but it all started in one day. We have already started and we are seeking partners in nations to join us on this path to the future.

We went armed with a battery of little things to the pharmaceutical store, and the bill came to $376, and he almost had another heart attack.

Health care services are seen to be terribly inadequate for the mentally ill, those who suffer due to alcohol and drug abuse, physically and sexually abused women and children, children in poverty and native peoples. The social and economic costs of these problems are immense.

- The inappropriate use of medical care - particularly physician and hospital emergency services - is widespread and costly. The public, and physicians, must be educated on when, why and how to use health care services.
- The cost of prescription drugs, the improper use of prescription drugs and the influence of the pharmaceutical companies on prescribing patterns is also of concern to you.

There are about 400,000 young people in the age group 10-19 years in BC. We are fortunate that the majority of them enjoy an excellent health status. Studies of the youth population in our province show that they are taller, slightly heavier, and more knowledgeable about healthy behaviours than their counterparts in the rest of the country.

Hospitals:

- There are over 11,000 references to hospitals in our files. The concerns you raised ranged from the inappropriate use of acute care beds and hospital services to capital costs, waiting lists and outreach to communities. There is a need for interpreters, culturally sensitive care, alternative therapists within hospitals and more hospital involvement in health promotion and illness prevention.
- Hospital boards and staff told us that they are under intense and unrelenting pressure to provide more service within existing budgets. At the same time, they are struggling to cope with recruitment/retention problems, and aging facilities and physical plant.
- Six of the province's nine tertiary care hospitals are sited in Vancouver. They also serve as community hospitals for a large and culturally diverse population. Open door policies in the emergency departments at these hospitals mean that they are used, or misused, as drop-in clinics.
- Submissions from teaching hospitals stress their importance as provincial centres of excellence for clinical education and research.
- While some of you talk of a *hospital without walls* that integrates hospital services into the community it serves, a number of communities worry about *walls without staff* in an evermore

technically advanced health care system.

• Hospital workers, in general, asked for a safer workplace, fairer workloads and more control over working conditions.

• Concern for the efficient management of hospital services and the need for suitable and accurate information systems were central themes at a number of hearings.

Continuing Care:

• A number of you describe continuing care in BC as "first class."

• There is a rising demand for continuing care services for the physically ill, mentally ill and the frail elderly. Your submissions suggest it will get worse if action is not taken soon.

• The elderly have the greatest need for acute hospital care, but a growing number of them are unable to return safely to their own homes after treatment in hospital. Instead, they wait in hospital for a vacancy in a continuing care facility.

• Community care and in-home care must play a bigger role in caring for the elderly. Both are socially and economically preferable to institutional care. Some of you say that funds should be diverted from acute care hospitals to continuing care facilities organized to support the local community with services such as adult daycare.

• There is a general concern that facilities be properly designed to meet the special needs of residents with Alzheimer's disease. The separation of the mentally disordered from those who are physically infirm is seen as necessary to maintain a high quality of life for residents in continuing care.

Palliative Care:

There can be great suffering in the end stages of cancer, AIDS and other illnesses. The right to die with dignity must be supported with appropriate resources and by improving and increasing community-based palliative care programs.

We must constantly strive to improve our medivac systems. These are expensive, but a valid cost of civilization - right up there with domed stadiums and expensive abstract art.

Affordability

• Travel costs from rural BC to regional centres for diagnosis or treatment are high and are usually paid by patients and families. At best, this adds another dimension of stress to illness in rural areas. At worst, it is an insurmountable barrier to care.

• Advances in technology improve care but also tend to raise costs. One example you give is the "pain-pump" which uses medication cassettes to automatically infuse people in severe pain with maintenance doses of pain-killer. The medication, usually an opiate, is relatively cheap but the cassettes can cost over $3000.00 a month. Pharmacare does not fully cover the cost of medications for all palliative care patients.

Poor people have fewer teeth than other people. We can't afford dental care. We get them pulled. Going to a dentist means taking food out of the mouths of our kids.

It would be advantageous to set up health clinics for the various cultural groups, including the Chinese. A brilliant example is a health clinic which at this moment is serving the needs of the many needy citizens in the downtown area.

The Community:

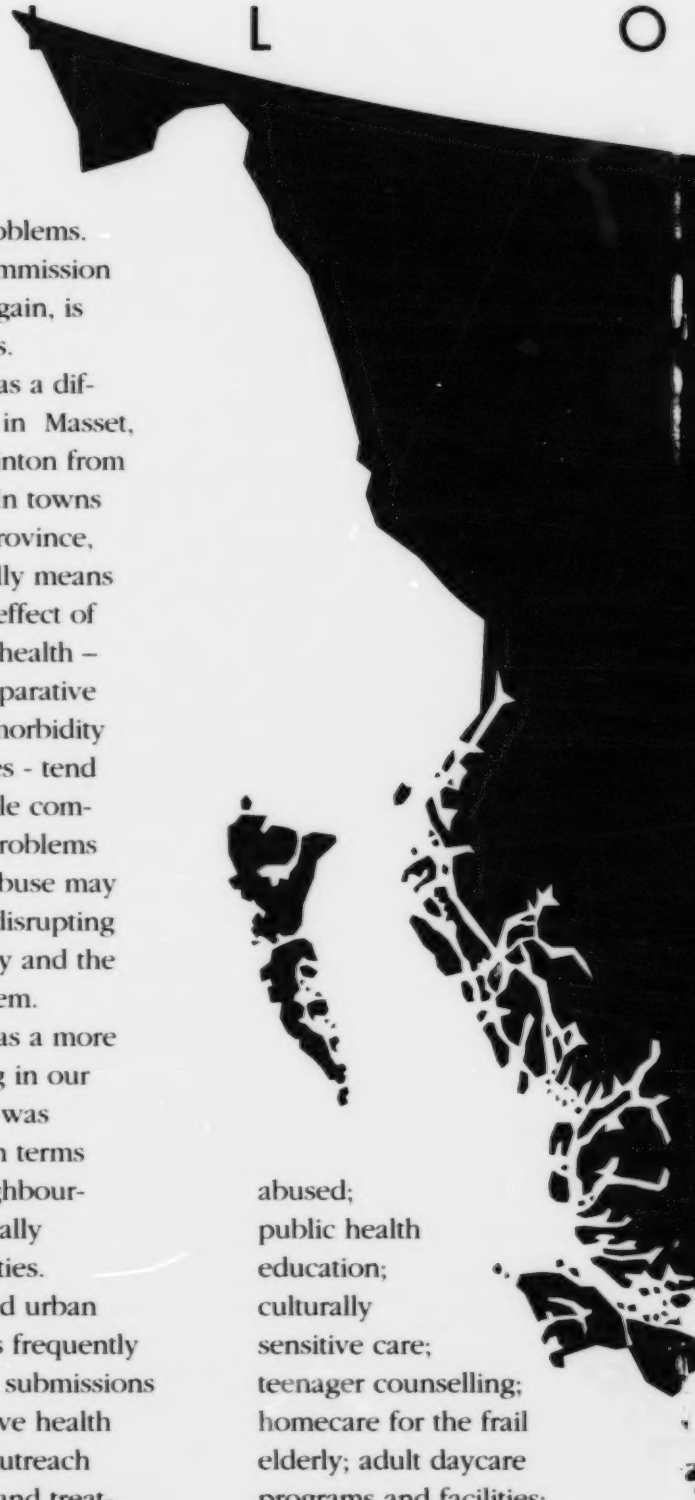
There is a positive and powerful sense of community throughout your submissions. There is also wide support for an increased emphasis on community-based health care, designed and funded to meet the specific needs of our communities.

What were once depicted as social problems you now describe as community health problems. Health, as the commission heard time and again, is critical to all of us.

Community has a different dimension in Masset, Revelstoke, or Clinton from our larger cities. In towns throughout the province, *community* literally means *all of us* and the effect of generally poorer health – indicated by comparative rural and urban morbidity and mortality rates - tend to be felt by whole communities. Here, problems such as alcohol abuse may affect everyone, disrupting the local economy and the whole social system.

Community has a more complex meaning in our cities. Vancouver was often described in terms of individual neighbourhoods and ethnically distinct communities.

Some rural and urban community needs frequently mentioned in the submissions are: comprehensive health clinics; hospital outreach programs; detox and treatment centres; crisis centres; sheltered housing for the mentally ill; support for the abused; public health education; culturally sensitive care; teenager counselling; homecare for the frail elderly; adult daycare programs and facilities; caregiver support; health promotion and illness prevention initiatives.



My point is that if community health is the way of the future then funding must be constant to prevent community health nurses and community facilities from drowning in the unmet service requests.

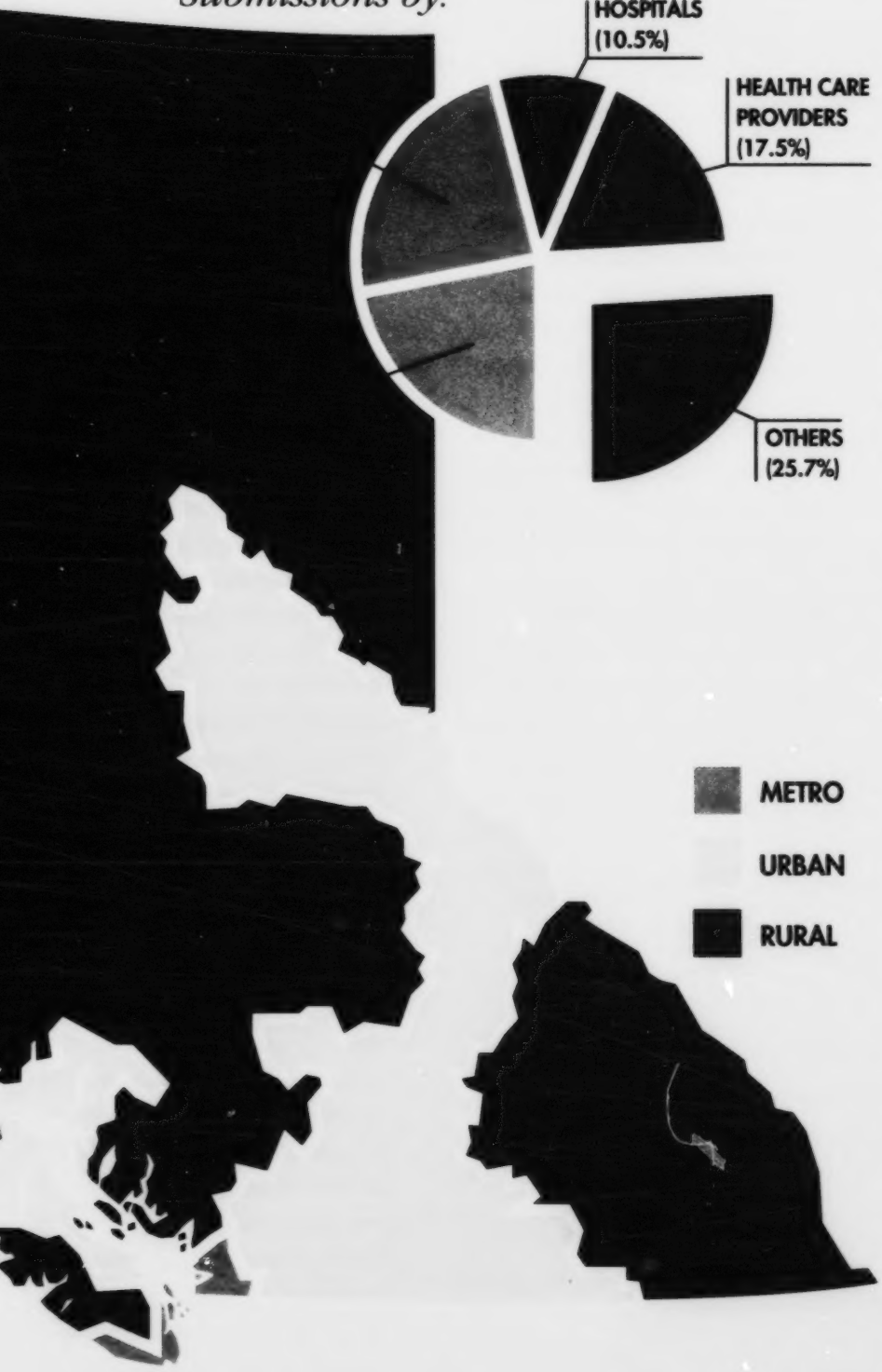
My sense of what creates a healthy community is citizen participation... not just meeting, but action... taking more control

F U S

Submissions by:

Breakdown of OTHERS

Professional Associations	32.4%
Unions	17.0%
Educators	15.1%
Health Units	6.6%
Native Interest Groups	6.1%
Municipal & Local Governments	6.1%
Regional Hospital Districts	4.8%
BC Government	4.2%
Suppliers	4.2%
Others	1.3%
Employer Councils	1.1%
Federal Government	1.1%



BC Population by
Regional Hospital District
and Urban/Rural Distinction: 1991

1991 Population
Regional/Referral Hospital

RHD	TOTAL	% BC
RURAL	574,517	18.00
URBAN	801,782	25.00
METRO*	1,826,885	57.00
TOTAL BC	3,203,184	100.00

1991 population estimates are projections based on the 1986 distribution.

* Metro has population centres greater than 100,000 and tertiary care centres.

Rural Communities: *"We're too far from Victoria."*

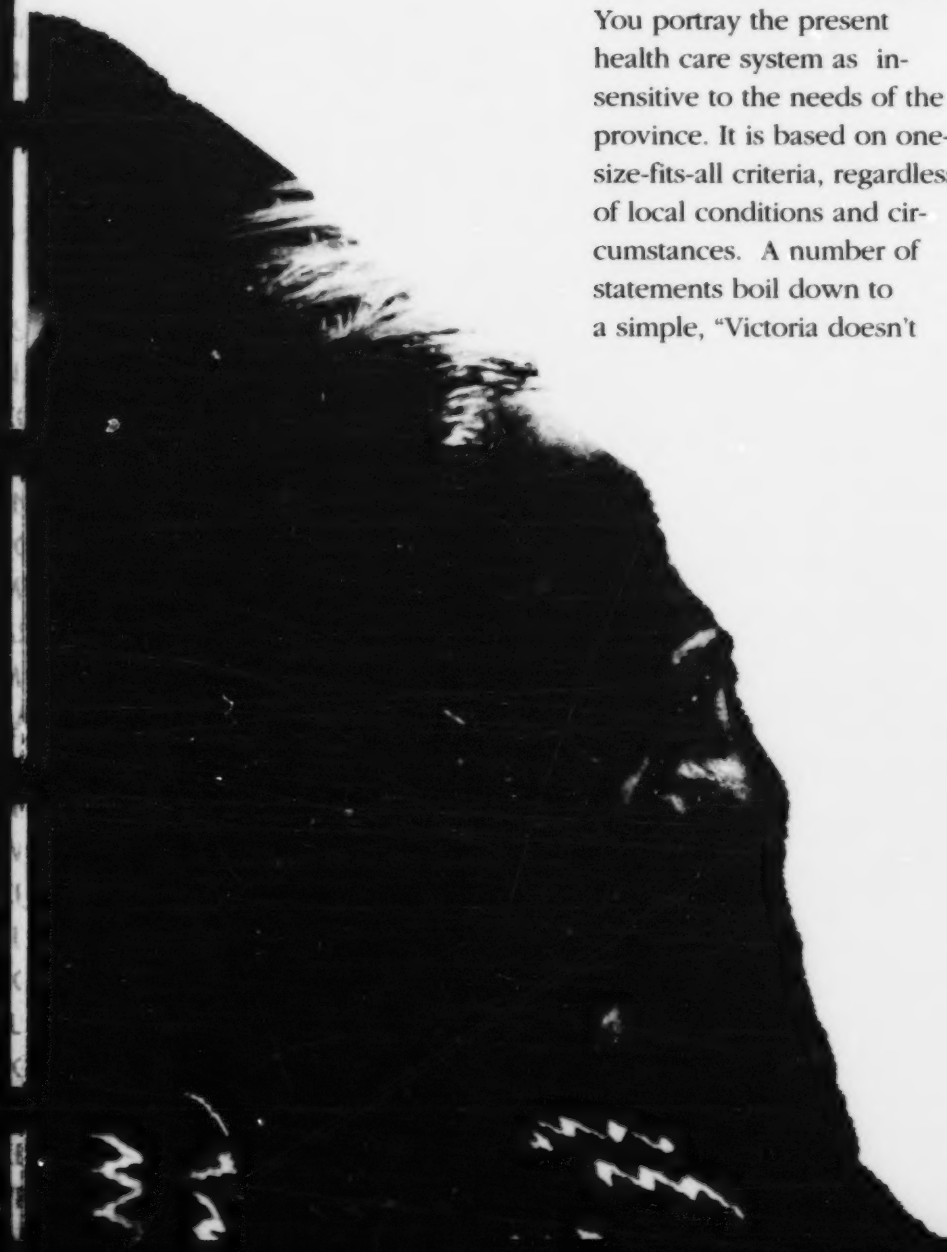
A large number of submissions describe the north and other remote areas of the province as poor relatives in our health care system.

You feel that few attempts are being made to address the major health problems, or to relieve the need for suitable health care services. You portray the present health care system as insensitive to the needs of the province. It is based on one-size-fits-all criteria, regardless of local conditions and circumstances. A number of statements boil down to a simple, "Victoria doesn't understand how we function here. It doesn't understand the practical difficulties we face."

The general tenor is one of urgency, of dedicated people under pressure. Frustration is evident in many areas.

Many of you propose that more autonomy and local control over health care resources and services could lead to better community health. Some of you recommend regionalization of the health care system, but a far wider theme is the need for more local responsibility and authority and the proper funding of health care services.

Some submissions acknowledge the tremendous difficulties that the government and its ministries face in providing health care. But there remains a widespread belief that, although some positive changes are occurring, centralized control does not work well. The level of expectation is not unrealistic. No one is requesting an MRI scanner for Kitimat. It is the capacity to meet basic health needs and to achieve reasonable standards that is asked for.



The Health of Native Peoples

"Our young men walk with their heads down..."

Third World. That is how you describe the health status of native peoples in British Columbia. No other single group carries such a burden of chronic health problems.

- infant mortality is twice the national average
- death from suicide is three times the national average
- death from motor vehicle accidents is five times the national average
- death from diabetes is six times the national average
- the incidence of tuberculosis is fifteen times the national average

We're saying there should be culturally appropriate materials developed in terms of our community, and they're saying, "Well these are what we've got."

The Commission has been told how native communities are working to achieve better health in the face of daunting odds. We have been told how gaps in health care services to all rural British Columbians are forced wider for natives through discrimination and racism. How federal and provincial jurisdictional disputes confound and complicate attempts to improve native health. How it is inefficient for money to be allocated by bureaucrats who have no idea what policies and programs are needed or are effective for aboriginal people in BC.

Under the current system, we are just going to continue losing our people

Native British Columbians ask for the understanding and resources necessary to help change the patterns of ill health that have plagued generations and continue to damage and destroy so many people. Native peoples want to control their own health.

Immigrants

A number of submissions point out that the lower mainland and Vancouver remain the destinations for a large number of immigrants whose approach to health care can be very different from that of the majority. This creates demands for interpreters, specialized health education programs and culturally sensitive resources.

A major group we're not reaching is the immigrant population. The East Indian, the Chinese and especially the Vietnamese...

When we remember the grief and the wreck
We wonder where was our pride and self respect.
It was there, but lost in our mind
It was in a bottle of a different kind
But we can change that tonight or tomorrow.

Verna Charlie
Fort Ware, B.C. 1990

H E A L T H C A R E

Health Care Workers in the Rural Communities

There is a strong sense of appreciation for the health care workers in your communities. However, the chronic shortage of workers in all fields of health care is a major concern in rural BC. Choosing the best person from a selection of good candidates is not a luxury your communities enjoy. The reality is that you take what you can get.

You speak of a need: for health care generalists; for doctors able to handle a wide range of problems, including minor surgery and obstetrics; for community nurses; for professionals trained in the special requirements of rural practice; for specialists of all kinds.

The need for mental health workers and rehabilitation therapists is particularly acute. The difficulty in attracting health care workers to rural communities and in retaining those that are already there affects small communities.

Physicians:

There are many suggestions as to why doctors are reluctant to practice in rural communities. However, the fact remains that there is a shortage of doctors in rural BC. A small number of "old-fashioned country doctors" are still in practice, but their numbers are dwindling.

There is strong support in your submissions for strategies that offer doctors greater incentives to practice rural medicine.

Nurses:

The demand for nurses in rural areas is high and the supply is low. According to one submitter, the only way new nurses enter the rural health care system is when their spouses' work means moving to the area.

The generalist nurse - the "country nurse" - is said to require an unusual breadth of knowledge and practical experience. In areas where physicians may not be immediately available, hospital nurses may be called on to provide primary management of major trauma, mental crises and medical emergencies.

Skill and the capacity to cope well with a variety of needs, patients and cases – sometimes under substantial pressure - are the hallmarks of a good rural nurse.

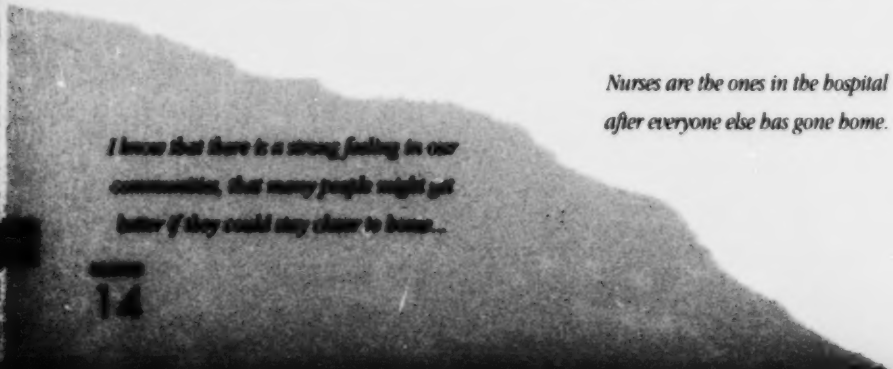
Other Health Care Workers and Support Personnel:

Traffic accidents and industrial accidents take a heavy toll on rural communities. Yet long waiting lists for rehabilitation therapists are the rule.

The special needs of children are constantly mentioned. Disabled children and the parents of disabled children need help coping with sensory deficits and mental and physical disabilities, but services are woefully inadequate.

For the elderly, a high quality of life commonly described in submissions as being able to remain at home and function at home as well and as long as is possible – depends on maintaining or

Nurses are the ones in the hospital after everyone else has gone home.



I know that there is a strong feeling in our communities, that many people might get better if they could stay closer to home...

improving physical functions. They need expert help.

Training and Education: There is a strong feeling that the practical requirements of rural practice are not well met by the present system of education. You want better access to the educated and the trained, and you want to influence their education and training.

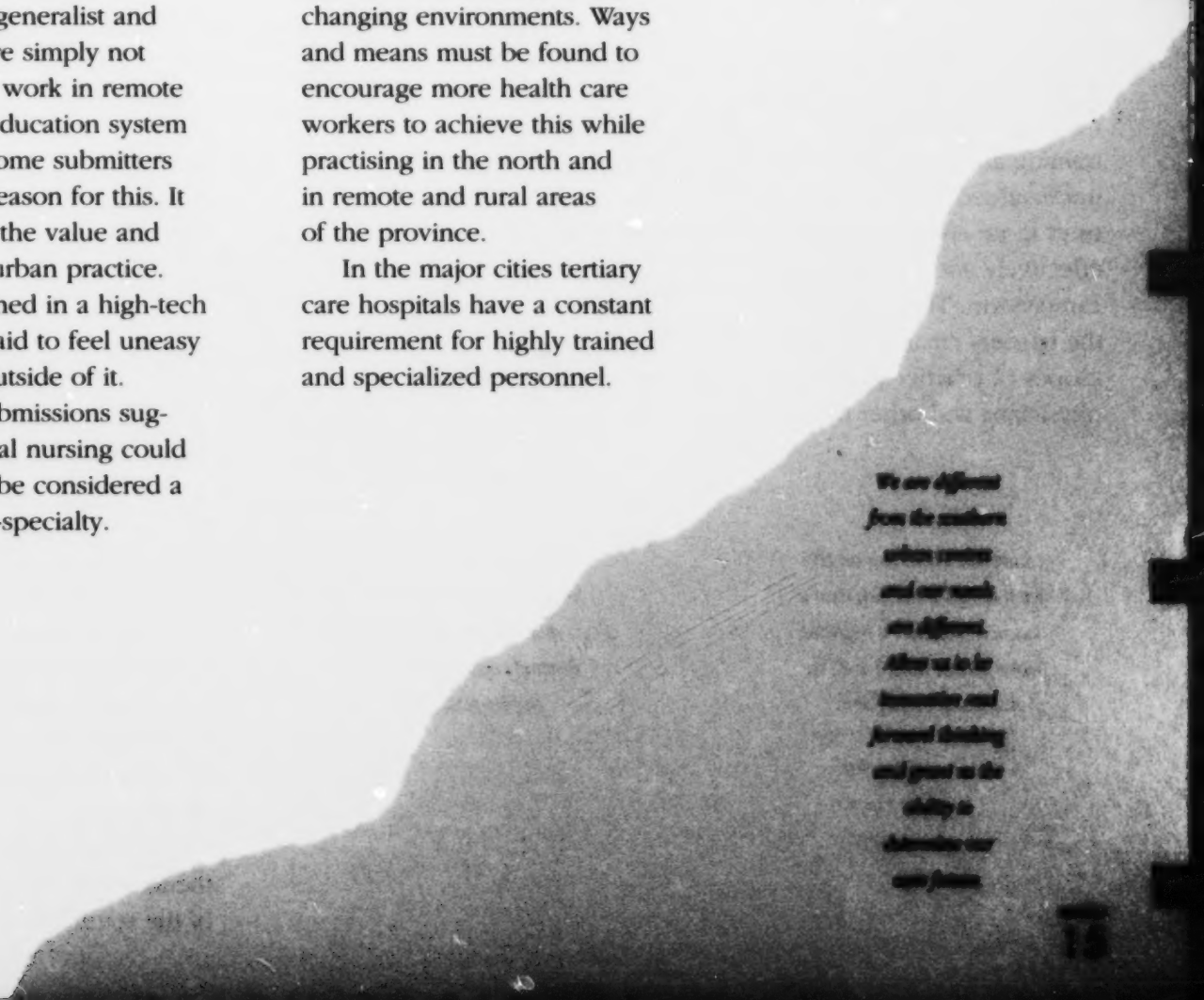
Canadian-trained physicians, generalist and specialist, are simply not choosing to work in remote areas. The education system is seen by some submitters as a major reason for this. It emphasizes the value and rewards of urban practice. Doctors trained in a high-tech milieu are said to feel uneasy practising outside of it.

Some submissions suggest that rural nursing could and should be considered a nursing sub-specialty.

Manpower

A number of your submissions call for a comprehensive health manpower strategy that matches the supply and training of workers with the needs of the local community. Ongoing education is also a major theme. People in the health care field need to keep up-to-date, extend and maintain their skills and learn what is essential for working in fast changing environments. Ways and means must be found to encourage more health care workers to achieve this while practising in the north and in remote and rural areas of the province.

In the major cities tertiary care hospitals have a constant requirement for highly trained and specialized personnel.



T E R R I T O R Y

According to a number of professional associations and unions, scopes of practice – who is allowed to do what to whom and under what circumstances – are a source of conflict. Your submissions also state that, contrary to their purpose, present legislation and regulations governing the health care professions tend to protect the professions at the expense of the public.

• Registered Nurses (RNs) claim that their education, training and experience are undervalued and should be used more efficiently and effectively within the health care system. They feel that the barriers created by the scopes of practice granted to physicians and other health care workers hamper their efforts to provide better care.

RNs also feel that an increasing emphasis on community care will require an expansion of their role into new territory as well as into territory solely occupied by physicians.

Some of the topics raised by nurses and felt to be within the natural province of their profession include: homecare and monitoring; own-home nursing; palliative care; public health; family health; illness prevention; health promotion; public education; hospital outreach; the nurse as point of entry into the health care system; nurse referral to specialized health care resources; nurses as primary care-givers; nurses as coordinators, facilitators, educators, counsellors.

I think that when I was an LPN that it worked better then than it does now. You were a respected person on that team. I don't see that today, I really don't.

The demand for increasingly academic qualifications is a demand created by the professionals.

• Licensed Practical Nurses (LPNs) argue strongly that they can provide expert and safe care in acute care hospitals as part of a nursing team. They feel that the trend towards hospitals replacing LPNs with RNs is wasteful of both money and talent, especially since hospitals are complaining of a chronic shortage of nursing staff.

•Physicians are criticized by chiropractors who allege that they restrict the appropriate practice of chiropractic as an alternative to medical therapy. Other non-medical therapists - naturopaths for example - have similar complaints.

There are other hot disputes.

• Fee for service vs. salaried physicians
• Sickness care vs. the promotion of health and prevention of illness
• Primary nursing vs. team nursing
• Appointed hospital boards vs. elected hospital boards
• Centralized health services vs. decentralized health services
• Use of alternative therapies vs. maintenance of the status quo.

MENTAL HEALTH

The care of the mentally ill has always been relegated to a low place in our health care system, but outside of our cities, you describe it as being virtually non-existent. Both urban and rural submissions describe a lack of facilities, a lack of psychiatrists, a lack of social workers, a lack of funds, a lack of everything.

Although drug therapies have enabled many of the mentally ill to leave institutions and live in the community, most still need some help.

My son left a suicide note on his pillow to tell us that he loved us very much and he went out somewhere after one o'clock in the morning and committed suicide..

Yet the resources to support the government's policy of down-sizing Riverview Hospital are largely unavailable, placing a burden on existing programs and facilities.

More psychiatrists are needed, yesterday.

There is a need for secure homes and more professional help within urban and rural communities. There is a need for psychogeriatric specialists and psychiatric nurses. There is a need for out-reach programs and counselling. There is a need to strengthen patient rights. There is a need for community care. There is a need.

Sexual Abuse

Again and again your submissions state that the sexual abuse of children is totally unacceptable. We must commit more resources to helping and healing those that have been so terribly hurt.

I'm dealing at the crisis level, and often feel very ineffective to stem the tide of pain that results from sexual abuse.

There is a deep need in human beings to celebrate life as well as to conquer ill health.

What You Said

Pregnancy

• Good primary and prenatal care in pregnancy is essential, yet there is a lack of both in many communities.
• High risk pregnancies need expert monitoring and management.
•We need to stress the fact that alcohol and pregnancy don't mix.

Because his mother drank,
Adam is one of the earth's damaged. Did she
have the right
to take away Adam's curiosity,
the right to take away the joy
he could have felt at receiving
a high mass or in reading a book,
in wondering at the complexity
and quirks of nature?
Did she have the right
to make him an outcast
among children?
To make him friendless,
to make his sexuality a problem
more than a pleasure,
to split his brain,
to give him violent seizures?

The Broken Cord by Michael Dorris
(read into proceedings)

Birth

• Pregnancy and childbirth are natural processes requiring careful support rather than medical intervention from the health care system. Legalizing midwifery is a sensible and cost effective move.
• Neonatology and infant life support techniques have radically improved the chances for survival of high risk newborn babies. But dangerous prematurity and low birth weight still increase the probability of long-term health problems for these infants.
• Neonatal Abstinence Syndrome - babies born addicted to chemicals - is a growing problem in the province.

Infancy

• Breastfeeding provides perfect nutrition, protection against disease and bonding between mother and child. Mother's milk is best.
• The marketing strategies of infant formula manufacturers raise a number of concerns.

Childhood

• Good nutrition, personal hygiene, safety in the home and road safety remain at the centre of childhood health.
• Accidents are the leading cause of death for young children. Some suffer permanent damage and need extensive care and rehabilitation for prolonged periods.
• The most important health care available to children should be in the home and in the family environment. Unfortunately, not all homes and not all families support the health of children.

Frightening statistics on child abuse in BC were laid before the commission. The Ministry of Social Services and Housing investigated 32,962 cases of child abuse and neglect in 1988/89. Half of the 700 abused children treated at Children's Hospital in Vancouver in 1990 were under 5 years old. Children's caseload has quadrupled since 1983. Physical and sexual abuse affect individual self esteem. They are strongly associated with the development of mental health problems and dangerous lifestyles.
• Developing language and communication skills is crucially important in integrating children into society. Long waiting lists for audiology and speech therapy services are a chronic problem.
• The needs of very sick and handicapped children profoundly affect their

families. Equipment and the cost of repeated travel to treatment centres places financial and emotional strain on families in BC. Even a short break from caregiving may be desperately far off. Parents need help too.

Adolescence

• Most of the problems that bring adolescents into contact with the health care system are avoidable. Violence, motor vehicle accidents and suicide have tragically high incidence among the young.

• Peer pressure is a major factor in the widespread use of tobacco, drugs and alcohol. Adolescents from poor families are in particular danger.

• There is a vital need for young people to learn sexual responsibility. Public health nurses report that Chlamydia and other sexually transmitted diseases are causing infertility in adolescent women at an alarming rate. The spread of AIDS among the young cannot be ignored.

Maturity

• We do not act responsibly. We must learn to change unhealthy lifestyles that are directly responsible for many of our illnesses.

• The toll from diseases such as cancer and cardiovascular disease is high, the cost enormous. The evidence is that much of this type of illness can be prevented or its effects reduced through changes in lifestyle such as adopting a sensible diet, giving up smoking, more exercise.

• Most seniors are healthy, their life experience a valuable resource for our society, but support is needed for the rapidly growing population of elderly and frail elderly in BC. There is concern about: home support, community care, care being provided closer to home, hospital outreach, continuing care, facility design, placement problems, waiting lists, mobility, functioning, physiotherapy, occupational therapy, adult day care, respite care, nutrition, alternative therapies, competency, financial aid, alcoholism, the abuse of medications, over medication, the abuse of the elderly, dementias, Alzheimer's disease, caregiver burnout.

Dying

• There is a profound need to care for the terminally ill. The right to die with dignity must be supported and there must be a basic change in attitudes and society's approach to death.

• There must be palliative care for those suffering from painful terminal illness. When cure is no longer an option, the health care system should supply the resources to manage the pain and provide physical and emotional care in the home, or a suitable environment, to support the dying patient.

• We should establish hospices in every community.

The perpetual longing for greater perfection which stirs human hearts and minds reflects a deep seated and mysterious call to transcendence. Without the experience of the limits imposed by pain and suffering there can be little authentic exploration of the depths of joy and inspiration.

THE FUTURE

That's the past. What about the future?

Age is everybody's future,
in this room and everywhere else.

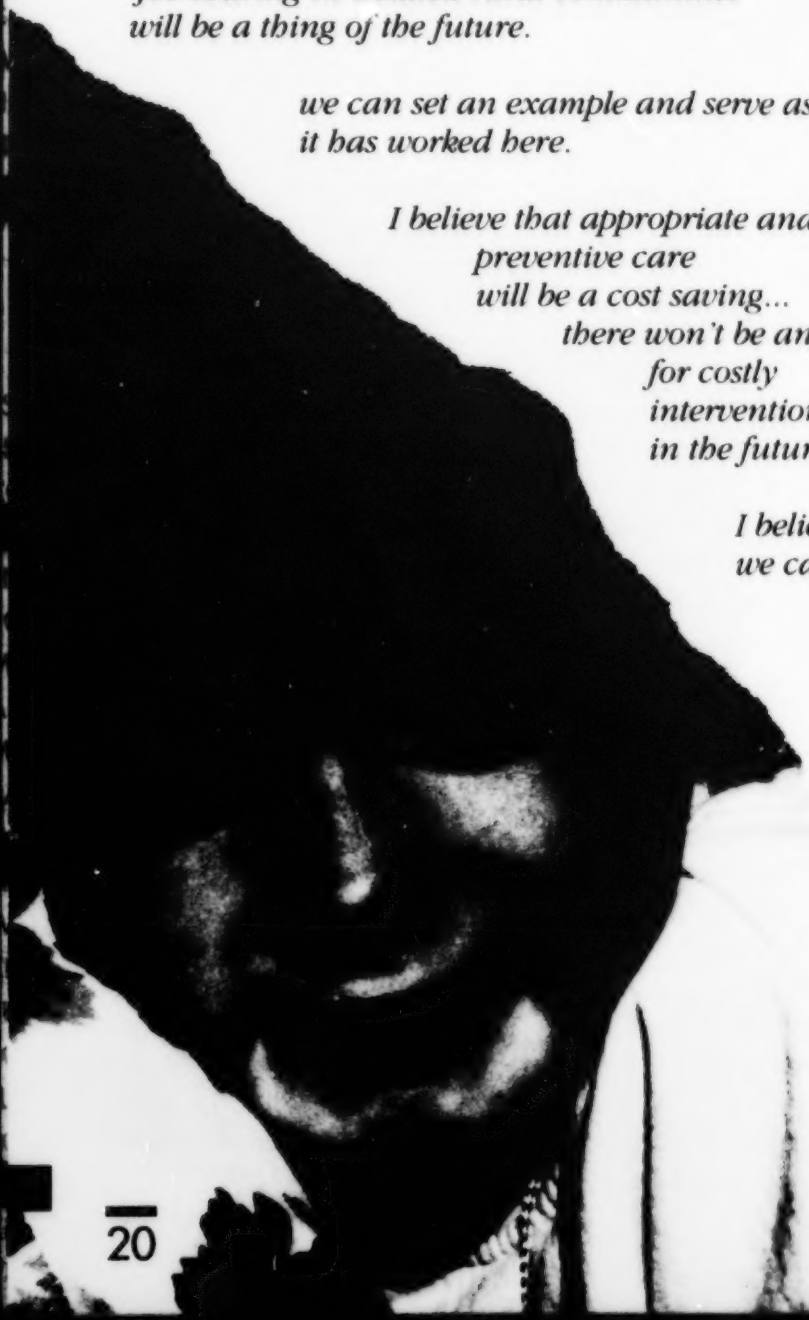
good health care can be affordable in the future...

job sharing in isolated rural communities
will be a thing of the future.

we can set an example and serve as a model...
it has worked here.

I believe that appropriate and
preventive care
will be a cost saving...
there won't be any need
for costly
interventions
in the future.

I believe that
we can..



Health Promotion and Protection

An ounce
of prevention
is <u>still</u> worth a
pound of cure.

A number of you express frustration that the present system is not cost effective in dealing with many health problems. There is a feeling that health education and promotion, and illness and injury prevention initiatives are not prominent enough or adequately funded.

In general you feel that it is better to educate than to operate; to intervene earlier than wait until intervention is costly and possibly less effective, and; to fight to prevent such things as AIDS than to leave our children to face the consequences of insufficient action and ignorance.

"Pay now, save later" runs as a motif throughout your submissions.

I think that you've been very patient in listening to us, and I think the people have very eloquently presented their material. It was not done in any sense of confrontation. It was done with dignity. And that was a word that was mentioned a lot today by a number of people. When you are in need of health services you need to be respected, and you need to be treated with dignity.

The final word? There is no final word. You have done a great deal of work. Now we will do our best and, I hope, do something useful together. Thank you. You have been very generous.

Chairman